

Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-HELP
(213) 897-8921
www.insurance.ca.gov



AUTO BODY REPAIR SHOP REPORT FORM

Name of Automobile Body Repair Shop:	Business Phone:
Address:	Name of Reporting Person:
City : State: ZIP:	Position:

1. Complete name of insurance company involved :
2. Are you reporting a denial in an insurer's Direct Repair Program? Yes _____ No _____ If Yes, Skip to Question 8.
3. Type of Insurance: AUTO
4. Name and Address of the policyholder/claimant/customer:
5. Policy identification number:
6. Claim number:
7. Date loss occurred or began:
8. Name of Adjuster or Insurance Company Representative:
9. Have you reported this to any other governmental agency? Yes ___ No ___ If yes, Please give the Name of the Agency: _____ File number, if known: _____
10. Have you previously written to the California Department of Insurance about this matter? Yes ___ No ___ File number (if available) _____ Date submitted _____

11. Briefly, describe the details of the transaction and provide any documentation to support your allegations.

Signature

Form: 902 (Revised July 2003)

Date _____